



James A. Haley VA Hospital

Post-Deployment Rehabilitation and Evaluation Program

Military Referral Packet

Mission Statement:

Our mission is to provide each service member with compassionate, state-of-the-art treatment services focusing on rehabilitation and mental health needs. Community reintegration and a comprehensive plan for restoration of function are paramount. Our goal is to assist in improving functional abilities, reduce symptom complaints, stabilizing psychological distress while restoring confidence and a sense of mastery, enhancing family relationships, and assisting veterans/service members with ongoing recovery.

Program Overview:

PREP is an inpatient rehabilitation program that specializes in the evaluation and treatment of complex reactions and symptoms associated with possible mild TBI and post-deployment adjustment difficulties. These unique programs encompass two phases:

PHASE I: Includes a 1-3 week comprehensive individualized evaluation to examine physical, cognitive, and mental health symptoms, and develop an individualized treatment plan.

PHASE II: Our treatment program provides intensive treatment for post deployment/combat related injuries encompassing both physical and mental health sequelae, including PTSD and other post-deployment readjustment issues. Treatment is collaborative and facilitated by an interdisciplinary team that can address both rehabilitation and mental health needs simultaneously.

Individualized treatment plans commonly include:

Vestibular (balance) Rehabilitation
Individual PTSD treatment (Prolonged Exposure)
Cognitive Rehabilitation
Recreation Therapy/Community Reintegration
Relaxation Training / Yoga
Post-deployment Adjustment Therapy
Audiological Rehabilitation

Pain / Headache Management
Insomnia/ Sleep Apnea Treatment
Physical Therapy / Core Strength Training
Medical/ Medication Management
Multisensory Evaluation/Treatment
Vocational Rehabilitation
Vision Therapy



For additional questions about the program please contact:

Telephone: (813) 972-2000 or Toll Free: (888) 716-7787

PREP POC at ext. 3415

Email: carlos.rivera5@va.gov

Admission Coordinator at ext. 6149

Email: Debbie.Shepherd@va.gov



James A. Haley VA Hospital

Post-Deployment Rehabilitation and Evaluation Program

Patient Agreement

Agreement

- I am willing to be admitted to PREP for at least 1-3 weeks. However, depending upon your individualized evaluation/treatment plan, your length of stay may be shorter or longer in duration.
- I agree to comprehensive evaluation including (but limited to): physiatrist, neurology, physical therapy, psychology specialists, psychiatry, neuropsychology, speech therapy, social work, occupational therapy, vocational therapy, vision, and/or audiology.

_____ I agree to attend daily scheduled therapies. Routine absenteeism from scheduled therapies
(Initials) (without prior approval) may result in early discharge from the program.

- I agree to attend weekly progress rounds, during which time treatment goals and progress will be addressed. This is your opportunity to participate directly in your medical care.
- I agree to engage in scheduled social and physical activities specific to your individualized treatment plan (e.g., playing sports, aerobic exercise, yoga or dining out with other veterans/service members).

_____ I agree to abstain from alcohol/illicit drugs, to abstain from non-prescribed drugs and to use
(Initials) prescribed medications as directed. You may be asked to provide a urine sample or take a breathalyzer for drug/alcohol screening at the team's request. **Note:** *Violation of this rule will be deemed you to be non-compliant which will be reflected in your medical records.*

- I agree, upon admission, to turn over ALL medications to the team nurse as hospital policy dictates patients are not allowed to manage/take their own medications while an inpatient. We reserve the right to search your room and/or belongings for medications in order to ensure your safety and the safety of others.
- I agree to keep my treatment CONFIDENTIAL from other patients.
- While you may be kept busy throughout the day, evenings and weekends are considered free time. We encourage you to use this time to continue to work on your treatment goals (e.g. completing assignments, exercising, socializing).
- Evening and weekend passes are given at the discretion of your medical provider, but are ultimately a treatment team decision. Anytime you leave hospital grounds without staff you need a pass.
- I understand that acts of physical or verbal violence against staff or other patients will not be tolerated and will result in immediate expulsion. I will treat each patient and team member with respect and will be treated with respect in turn.
- Non-compliance with the above agreement and guidelines may lead to an early discharge.

I, _____, have been provided information regarding admission expectations and agree to abide by these patient agreement and guidelines.

Signature

Date



James A Haley VA Hospital
Post-Deployment Rehabilitation and Evaluation Program
Military Referral Form

Please note that items marked with an asterisk (*) are required in order to process the referral.

Date of Referral: _____

*Referring Clinician: _____

*Phone Number/email: _____

*Referring Case Manager/Social Worker: _____

*Phone Number/email: _____

Referring Organization: _____

Service Member Name:	
Service Member SSN#:	
Service Member DOB:	
Service Member Address:	
City/State/Zip:	
Service Member Phone #:	
Service Member email:	

SERVICE MEMBER DEMOGRAPHICS

Military Status: ☐ Active Duty ☐ Reserves ☐ National Guard

Branch of Service: ☐ Army ☐ Navy ☐ Marines ☐ Air Force ☐ Coast Guard

Rank: _____

Marital Status: ☐ Never Married ☐ Married ☐ Domestic Partner ☐ Separated
☐ Divorced ☐ Widowed

Gender: ☐ Male ☐ Female

What is the patient's preferred language for discussing health care: _____

Does the patient currently utilize a Personal Health Information (PHI) system? (How do they manage their medical care and records?) ☐ Yes ☐ No

MEB process initiated? ☐ Yes ☐ No

If Yes, What is the current status?

Are there pending or history of military/civilian legal issues (Investigations, Line of Duty, arrests, etc)?

MEDICAL

Purpose of the referral to PREP?

Is the patient willing and able to fully participate in the program?

Date and Mechanism of Injury: _____

Any admissions/hospital stays within the past 60 days (Psychiatric/Medical):

What is the patient's current medication list?

What is the patient's current level of activity: _____

Does the patient currently use any equipment to assist with mobility or activities of daily living? ☐ Yes ☐ No **If yes,** _____

Are there any current activity limitations and restrictions? (Driving, limited duty profiles, etc.): _____

Are there any barriers to learning? _____

Are there any cultural and/or dietary preferences of the patient?

Other Comments: _____



Post Deployment Rehabilitation and Evaluation Program

What to Expect & What to Bring

You have been referred to the James A. Haley VA Polytrauma Rehabilitation Center PREP Program. To prepare for your stay, please review the information below prior to travel.

- ✓ Before you travel, please contact the PREP Program Case Manager to ensure accommodations are in order and we have your updated contact information.
- ✓ Please bring the following items if applicable:
 - Prescribed medications and/or vitamins
 - Hearing aids
 - Eye glasses
 - Braces/Splints
 - Tens Unit/Alpha Stim
 - CPAP machine
 - Medical records (if you already have copies)
 - DD214 (if available)
 - Toiletries (soap, shampoo, shaving cream, deodorant, toothpaste, etc.)
 - 1 weeks-worth of clothing, to include Gym clothes, Swim suit/trunks and sweater(s)
 - Laundry facilities, detergent and fabric softener are provided for your convenience
 - Sunglasses are allowed outdoors only
 - Comfortable shoes (tennis shoes, play shoes) & shower shoes
 - Please **do not** bring more than \$100 cash with you
 - Personal identification (VA ID, Driver's License, Military ID)
 - The following items are allowed: Laptop, IPAD, Cell Phone
- ✓ Items **NOT** to bring:
 - Firearms and/or other supplies/weaponry
 - Alcohol, illegal substances and/or mood altering substances
 - Chemical liquids (nail polish/nail polish remover)
 - Glass items, including glass picture frames
 - Non-prescribed medications (including creams, and over the counter medications)

Note: *There may be other items that the staff deems inappropriate during treatment and is not responsible for lost or stolen items.*

During admission:

- ✓ You will be admitted to the hospital for approximately three-four weeks. This length of stay may be extended or shortened as treatments are modified to each patient and their identified goals.
- ✓ You will be very busy with medical and mental health appointments, Monday through Friday from 8am to 4pm. Weekend and evening passes may be granted depending on your medical status.

Family Visitation: Family members are welcome to briefly visit our program. This is best accommodated either at initial admission or prior to discharge. Family meetings or telephone conferences can be scheduled to address ongoing treatment issues.



Post Deployment Rehabilitation and Evaluation Program Requested Medical Documentation

The following medical documents, if available, must be included as part of the referral packet or when requested by Medical Director. Please send documents in a secured electronic format (secured email or fax).

Neuropsychology:

Neuropsychology Report

Speech Pathology / Occupational Therapy:

Discharge Summary

Initial Evaluation and/or testing

Physical Therapy:

Physical Therapy Discharge Summary or most recent re-assessment notes

Recent Orthopedic assessments and imaging reports

Vestibular testing Audiograms, VNG testing

General Reports/Notes:

Current/Reconciled Medication List

Vision/Optometry Notes

Audiology Evaluations

Electronystagmogram / Electromyogram

Radiology Reports (*MRI, CT-Scan, Ultrasounds, Echocardiogram, Plain X-Ray reports*)

Mental Health:

Psychology and/or Psychiatric Notes

Any Special Consults/Procedures:

Endoscopy/Colonoscopy

Renal

Endocrine

Sleep:

Sleep Study Report / Polysomnography



PREP Packet Completion Checklist

Use this checklist to ensure referral packet is complete before submission. Incomplete **Referrals will be discontinued after 30 calendar days if missing documents are not received.**

- _____ Printed name, initialed/signed and dated PREP Patient Agreement
- _____ Completely filled out and dated PREP Referral Form, with Referring Clinician (MD, NP, and PA) and Referring Social Worker/Case Manager contact information.
- _____ Complete PREP Packet (provide as much information as possible and document N/A if not applicable)
- _____ Completely filled out and signed Military Treatment Facility Referral Form to VA Liaison (MTF) Referral Form, VA Form 10-0454
- _____ Completely filled out, signed and dated Acknowledgement of the Notice of Privacy Practice, VA Form 10-0483
- _____ Medical Records:
 - Medical documentation of TBI or events/symptoms leading to TBI suspicion (initial documentation and follow up notes/treatments within past 6 months)
 - Current Level of Functioning (current within past 6 months)
 - Current Medication List
 - Other Documents (per above list of documents)



MTF Case Manager/Social Worker: Please complete this form in its entirety, as all information is needed to register a patient with the Veterans Health Administration. Once complete, please return it to the VA Liaison for Health Care at your MTF. If there is not a VA Liaison assigned to your facility, please forward this form directly to the OEF/OIF Program Manager at the requested VA Health Care Facility.

Military Treatment Facility		Date of Referral
MTF Referral Source		Phone Number
		Cell/Pager Number
Military Social Worker/Case Manager (If different than referral source)		Phone Number
		Cell/Pager Number
VA Liaison for Health Care		Phone Number
		Cell/Pager Number

PATIENT PERSONAL INFORMATION

Last Name		First Name		Middle Name		Suffix
Full SSN		Home Phone Number		Cell Phone Number		
Complete Home Address (City & State & Zip)						
County		Email Address		DOB		Mother's Maiden Name
Age	Religion		Marital Status		Place of Birth (City&State&Zip)	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female		Is the patient Spanish, Hispanic, or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What is Patient's Race? (You may check more than one.) (Information is required for statistical purposes only.)			<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander			
			<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American			
Father's Name			Mother's Name			

EMERGENCY CONTACT

<input type="checkbox"/> Next-of-Kin <input type="checkbox"/> Family <input type="checkbox"/> Durable Power of Attorney for Health Care	
Name	Relationship
Complete Address & City & State & Zip	
Home Phone Number	Cell Phone Number
Does the Patient have an Advance Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PATIENT MILITARY INFORMATION: (complete details in these responses aid in the planning of long term veterans benefits)

Branch of Military	<input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Coast Guard	Rank
Component	<input type="checkbox"/> National Guard <input type="checkbox"/> Reserve <input type="checkbox"/> Active	<input type="checkbox"/> OIF <input type="checkbox"/> OEF <input type="checkbox"/> N/A (non-OIF/OEF)
Service Status:	<input type="checkbox"/> Active Duty (currently) <input type="checkbox"/> Retired - Date of retirement	<input type="checkbox"/> TDRL <input type="checkbox"/> PDRL
Service Entry Date	ETS	Release from Active Duty
Combat Dates & Theater (locations)		
Parent Command & POC & Phone Number		
<input type="checkbox"/> In process of discharge:	<input type="checkbox"/> ETS <input type="checkbox"/> MEB <input type="checkbox"/> Limited Duty	<input type="checkbox"/> Admin Sep <input type="checkbox"/> Other:
Anticipated date of separation (if known):		Status of MEB/PEB:

Patient's Last Name:	Patient's SSN:

MTF HEALTH CARE TREATMENT AND PLAN

Date of injury:

☐ BI ☐ NBI ☐ Disease/ Disorder

INJURY/COMBAT RELATED INJURY/DIAGNOSIS DETAILS:

DISCHARGE PLAN from Military Treatment Facility [to include WHEN and WHERE patient will be d/c & discharge status, i.e. TDRL, convalescent leave pending medical d/c, convalescent leave pending return to duty, Con Lv pending return to MTF, etc]:

1) What is the estimated departure date from MTF or arrival date home? (so VHA can arrange follow-up care):

2) Has MTF Case Manager requested a TriCare /MMSO authorization? ☐ YES ☐ NO If so when was clinical order entered?

3) Name of Attending Physician and Contact Number(s):

4) Name of Nurse/Nurses' Station Ward and Contact Number(s):

REQUEST FOR VA HEALTH CARE, Must be Completed by a MTF Health Care Clinician (i.e. Case Manager/SW/MD)

Requested VA Health Care Facility:

Is patient a VA Employee ☐ YES ☐ NOREQUESTED HEALTH CARE: *please check all that apply, and provide corresponding medical records.***INPATIENT CARE**

- ☐ Traumatic Brain Injury
- ☐ Spinal Cord Injury
- ☐ Mental Health (Psychiatry, PTSD, Substance Abuse)
- ☐ Blind Rehabilitation
- ☐ Long-term care/Nursing Home
- ☐ Other:

OUTPATIENT CARE

- ☐ Primary Care:
- ☐ Mental Health (Psychiatry, Psychology, PTSD, Substance Abuse):
- ☐ Therapy (PT, OT, Speech):
- ☐ Pain Management:
- ☐ Visually Impaired Services:
- ☐ Durable Medical Equipment/Prosthetics:
- ☐ Specialty Clinics (Neuro, Ortho, Cardiology, ENT, wound care, suture removal, Audiology):
- ☐ TBI/Polytrauma:
- ☐ Other:

Please indicate the plan for the transfer of Medical Records:

NOTE: At the time of the patient transfer the discharge summary and current discharge medication list will need to be included.*(if referring to an inpatient setting (i.e. Polytrauma Center, TBI, SCI), or if clinically indicated (i.e. ortho, surgery) please request a CD of patient's films)*

Patient's Last Name:

Patient's SSN:

[As appropriate:]	REFERRALS TO POLYTRAUMA WILL NEED TO INCLUDE THE FOLLOWING:
<input type="checkbox"/>	History & Physical
<input type="checkbox"/>	Notes from theater, Germany, Medivac flight note, etc.
<input type="checkbox"/>	MD progress notes. If pt has fractures include ortho note w/ weight bearing status & any other restrictions.
<input type="checkbox"/>	Include notes from Specialty Services i.e. neurosurgery, neurology, ID, plastics, ophthalmology
<input type="checkbox"/>	Current lab work: CBC, comprehensive metabolic panel, urinalysis, and others as appropriate (i.e. INR, arterial blood gases, etc)
<input type="checkbox"/>	Cumulative microbiology results
<input type="checkbox"/>	Cumulative results of cerebrospinal and any other fluid analysis (i.e. pleural, ascitic, synovial, etc.)
<input type="checkbox"/>	Current medications
<input type="checkbox"/>	Radiology reports for CT scans, MRI's, ultrasounds, vascular studies, special procedures, angiograms & list of radiology studies performed
<input type="checkbox"/>	OR notes (especially regarding all implanted devices such as pegs, trachs, stents, filters, etc.)
<input type="checkbox"/>	Recent therapy notes from OT, PT, & SLP
<input type="checkbox"/>	Neuropsychology testing performed
<input type="checkbox"/>	Social Work psychosocial assessment
<input type="checkbox"/>	Interim summary describing the hospital course and complications to date

Patient's Last Name:	Patient's SSN:
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U.S. Department
of Veterans Affairs

Acknowledgement of the Notice of Privacy Practices

Acknowledgement of Department of Veterans Affairs, Veterans Health Administration (VHA)
Notice of Privacy Practices

The signature below only acknowledges receipt of the VHA Notice of Privacy Practices, effective date 23
September 2013.

Signature of Patient/Patient Representative

Date

Name of Patient/Representative

Relationship to patient (if applicable)

Last four SSN